

# Idealistic, impractical, impossible?

## Shared decision making in the real world

A good idea but not so easy to put it into practice. This is how Blakeman and others in this month's Journal (page 407) describe the reactions of GPs to the 'expert patient' programme.<sup>1</sup> Doctors are supportive of the expert patient concept and yet admit that they struggle when it comes to working with the ideas and developing the specific knowledge and skills that are required by patients who aspire to this ideal. The new contract for general practice has also created a changed context for many consultations and both patients and professionals need to learn new skills to do this work. If self-management involves self-determination, there may be a conflict between what the patient chooses for themselves and what the contract prescribes. 'Expert patients', viewing the world from their individual standpoints, could well take issue with the population derived agendas set by incentivised consultations operating in UK primary care. I suspect these patients get short shrift in some practices.

On page 415, Lester and her colleagues describe another facet of the involvement story: there is public support for involving patients in decisions, in treating them as partners in the process of care: but scratch the surface, ask patients, analyse the transcripts and you uncover another world.<sup>2</sup> Notice the patient in this article reporting that the doctor 'wouldn't treat me if I didn't have medication. His way, or no way'. This is not the experience of a study outlier. The literature is full of research showing that the medical profession operates from a position of authority, control and directives.<sup>3-6</sup> We manage our workloads by exercising both overt and covert control over agenda setting; problem elaboration; solution generation; and closure. We are no longer in a position to say that it's because of a deficit in our training: the patient centred method has for decades been part of the educational framework and shared decision making is

central to doing well in the MRCGP examination. The reasons for not involving patients in decisions are deeper and more complex.

We need to consider, among many other issues, the role of the placebo phenomenon and the therapeutic impact of being positive in the consultation about a working diagnosis and proposed solutions.<sup>7</sup> There is new work being published about the nature of the placebo effect — that prior expectations modify its intensity.<sup>8</sup> If you create a set of positive expectations about a proposed solution (treatment) and close by being positive about the expected recovery, you are in effect orchestrating and modulating a placebo effect. How often have we all used this strategy to rapidly close a consultation that we wish had ended minutes earlier? I suspect it occurs more often than we care to admit or examine.

Compare this interaction with one in which shared decision making takes place: where the doctor admits a degree of professional uncertainty about the most effective treatment — a position that has been called *equipoise* — and where the clinician explores, with the patient, a range of possible options.<sup>9</sup> Both individuals then consider each option and weigh up the relative harms and benefits. I could argue, and indeed do argue and have observed, that if the process of sharing decisions is done well and with accurate risk data — it enhances the patient experience and creates a novel relationship of enhanced trust and partnership.<sup>10</sup> But we also know how doctors operate in the real world: it's seldom in line with this framework.<sup>11,12</sup>

Few, if any, patients have experienced genuine shared decision making so it's a little daft to ask them if they would like to have it. Shared decision making is not a phenomenon that occurs naturally because doctors, like others, operate to maximise their efficiency. They mostly go for low-hanging fruit, for quick wins where

they see them. I'm not arguing that these are deficiencies. Most doctors I know are highly skilled in this area — I don't accept that they are poor communicators. They are however, like all humans when talking, goal orientated not model orientated.<sup>13</sup> The patient-centred model and the shared decision-making model are idealistic constructions built by academic thinkers. They work well in controlled conditions; patients like them as they are, by definition, given more attention, their agendas are explored with more sensitivity and so on. However, in the time-pressurised and incentivised clinics we inhabit, we revert to achievable realistic goals, scope and prioritise tasks, using a variety of discourse mechanisms, then narrow down on a set of feasible problems that we know how to handle and generate a solution that we can confidently manage and operationalise. At this point, we typically close the interaction as smoothly as is consistent with a good ongoing relationship and move on to the next patient.<sup>14</sup> These are the rules of the game and as interactions are repeated, cooperation is rewarded and defections are 'punished', though normally nothing harsher than a change in eye contact or a shift in body language.<sup>15,16</sup> These are subtle but powerful guides for 'next time', nonetheless.

Injecting a set of incentives based on achieving biomedical indicators, or proxies, influences this communication process towards yet another set of goals. There are as yet few studies that have examined this issue in depth. There are reports, however, that patients, especially those with multiple long-term conditions, are pushing against calls to see the diabetes nurse today, the lipid nurse tomorrow and the repeat prescription review next week.

To summarise then, sharing decisions with patients isn't a trendy thing that's failed. The shift toward the ethical

principles of veracity, autonomy and beneficence at the individual level isn't going to be halted by the short-term gains of meeting targets based on population derived indicators. Our challenge is to conduct interactions with individuals where the risk-benefit equations are openly discussed and how we enable individuals to enjoy the freedom that self-management and self-adjusted dosing can provide: in summary, how to facilitate the autonomy derived from a good understanding of long term illnesses. Ironically, it will be patients who will push for this as the digital information era creates the need for better partnerships.<sup>17-19</sup> We are making progress even though we watch the clock and count the points.

#### Glyn Elwyn

Professor of Primary Care Medicine,  
Department of General Practice,  
Cardiff University

#### REFERENCES

1. Blakeman T, Macdonald W, Bower P, *et al.* A qualitative study of GPs' attitudes to self-management of chronic disease. *Br J Gen Pract* 2006; **56**: 407-414.
2. Lester H, Tait L, England E, Tritter J. Patient involvement in primary care mental health: a focus group study. *Br J Gen Pract* 2006; **56**: 415-422.
3. Campion P, Foulkes J, Neighbour R, Tate P. Patient centredness in the MRCGP video examination: analysis of large cohort. *BMJ* 2002; **325**: 691-692.
4. Britten N, Stevenson FA, Barry CA, *et al.* Misunderstandings in prescribing decisions in general practice: qualitative study. *BMJ* 2000; **320**: 484-488.
5. Barry CA, Bradley CP, Britten N, *et al.* Patients' unvoiced agendas in general practice consultations: qualitative study. *BMJ* 2000; **320**: 1246-1250.
6. Elwyn G, Hutchings H, Edwards A, *et al.* The OPTION scale: measuring the extent that clinicians involve patients in decision making tasks. *Health Expectations* 2005; **8**: 34-42.
7. Di Blasi Z, Harkness E, Ernst E, *et al.* Influence of context effects on health outcomes: a systematic review. *Lancet* 2001; **357**: 757-762.
8. Benedetti F, Mayberg HS, Wager TD, *et al.* Neurobiological mechanisms of the placebo effect. *J Neurosci* 2005; **25**: 10390-10402.
9. Elwyn G, Edwards A, Kinnersley P, Grol R. Shared decision making and the concept of equipoise: defining the competences of involving patients in healthcare choices. *Br J Gen Pract* 2000; **50**: 892-899.
10. Elwyn G, Edwards A, Hood K, *et al.* Achieving involvement: process outcomes from a cluster randomised controlled trial of shared decision making skill development and use of risk communication aids in general practice. *Fam Pract* 2004; **21**: 337-346.
11. Edwards A, Elwyn G. Inside the black box of shared decision making — distinguishing between the process of involvement and who makes the decision. *Health Expectations* 2006; In Press.
12. Saba GW, Wong ST, Schillinger D, *et al.* Shared decision making and the experience of partnership in primary care. *Ann of Fam Med* 2006; **4**: 54-62.
13. Austin JL. *How to do things with words*. Oxford: Oxford University Press, 1962.
14. Maynard DW. Interaction and asymmetry in clinical discourse. *Am J Sociol* 1991; **97**: 448-495.
15. Gutek BA, Groth M, Cherry B. Achieving service success through relationships and enhanced encounters. *Academy of Management Executive* 2002; **16**(4): 132-144.
16. Tarrant C, Stokes T, Colman AM. Models of the medical consultation: opportunities and limitations of a game theory perspective. *Qual Saf Health Care* 2004; **13**: 461-466.
17. Woolf SH, Chan EC, Harris R, *et al.* Promoting informed choice: transforming health care to dispense knowledge for decision making. *Ann Intern Med* 2005; **143**: 293-300.
18. O'Connor AM, Graham ID, Visser A. Implementing shared decision making in diverse health care systems: the role of patient decision aids. *Patient Educ Couns* 2005; **57**: 247-249.
19. Schattner A, Bronstein A, Jellin N. Information and shared decision-making are top patients' priorities. *BMC Health Serv Res* 2006; **6**: 21.

#### ADDRESS FOR CORRESPONDENCE

##### Glyn Elwyn

Professor of Primary Care Medicine,  
Department of General Practice, Centre  
for Health Sciences Research, Cardiff  
University, Neuadd Meirionnydd, Heath  
Park CF14 4YS.  
E-mail: [elwyng@cardiff.ac.uk](mailto:elwyng@cardiff.ac.uk)

# Identifying unmet health needs in older people: comprehensive screening is not the answer

The case for routine comprehensive screening for unmet health needs in the older population has collapsed. A very large randomised controlled trial in the UK has demonstrated that there are little or no benefits to quality of life or health outcomes from population screening,<sup>1</sup> endorsing the deletion of the obligation to offer annual screening from the contract for general practice in Britain. The evidence of benefit from such whole population screening had always been thin, and the UK's '75 and over checks' had stalled long before they disappeared quietly from the new GP contract, suggesting that a

mechanistic approach to needs assessment without a robust evidence base makes both bad science and bad policy.<sup>2</sup>

In contrast, the editorial<sup>3</sup> accompanying the paper by Fletcher *et al*<sup>1</sup> concluded that people over 75 should be offered 'preventative home visits' and argued that 'the common core is the multidimensional geriatric assessment, which helps to identify and manage the multiple problems and risks of older people'. The belief that screening could prevent functional impairment in older people has had an enduring appeal to researchers, clinicians,

and older people, since the original study by Williamson.<sup>4</sup> The accumulating evidence against the value of whole population screening is not going to extinguish this enthusiasm for intervention, and nor should it, since there is some evidence that needs assessment of older people followed by active management may improve survival and function.<sup>3</sup> Efforts to improve the health of an ageing population should logically focus on a two-stage process, with case finding leading to highly selective comprehensive geriatric assessment, as advocated by GPs over a decade ago.<sup>5</sup>